Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert Francis, DC

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-15-0400-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 26, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly. TDI-DWC addresses Maximum Medical Improvement (MMI) Evaluations with Rule 134.204 (J) Subsection (3), Subparagraph (C). This rule states to reimburse the examining doctor, other than the treating doctor **$350.00 for MMI evaluations.** TDI-DWC addresses Impairment Rating (IR) Evaluations with Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion, is performed, **reimbursement for the first musculoskeletal body area is $300.00 and each additional musculoskeletal body area is $150.00.**

MMI = $350.00
IR – Shoulder = $300.00
IR – Knee = $150.00
IR – Back = $150.00
IR – Chest = $150.00
TTL = $1100.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A review was completed by Coventry to determine if the additional $150.00 being pursued for the DOS 3-7-14 is warranted…

Coventry confirms their initial review determining $950 was owed is correct."

Response Submitted by: Gallagher Bassett Services, Inc., 16414 San Pedro Ave, Ste #950, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2014	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 defines the required elements for an explanation of benefits.
3. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - P1 – Code is not explained as required by 28 Texas Administrative Code §133.240 (f)(17)(H)
   - Note: This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.

Issues

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services based on a Workers Compensation State Fee Schedule Adjustment. 28 Texas Administrative Code §134.204 (j)(1) states, "The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR". Further, 28 Texas Administrative Code §134.204 (j)(3) states, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, **the fee schedule indicates that the correct MAR for this examination is $350.00**.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i)Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows… (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area. (D) …(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides… (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150".

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of cervical (with range of motion), lumbar (with range of motion), bilateral knees (with range of motion), left shoulder (with range of motion), and the chest. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the chest in the section for the Respiratory System. For this reason, it is considered a body system in the non-musculoskeletal category. The AMA Guides places the cervical and lumbar in the subsection for the Spine. For this reason, they are considered to be under the spine and pelvis in the musculoskeletal category. The AMA Guides places the knees in the subsection for the Lower Extremities. For this reason, it is considered in the lower extremities in the musculoskeletal category. The AMA Guides places the shoulder in the subsection for the Upper Extremities. For this reason, it is considered in the upper extremities in the musculoskeletal category. Therefore, **the fee schedule indicates that the correct MAR for these evaluations is $750.00**. See the table below for a detailed analysis.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]	$350.00
IR: Cervical (ROM)	Spine & Pelvis	$300.00
IR: Lumbar (ROM)		
IR: Bilateral Knees (ROM)	Lower Extremities	$150.00
IR: Left Shoulder (ROM)	Upper Extremities	$150.00
IR: Chest	Body Systems	$150.00
Total MMI	[redacted]	**$350.00**
Total IR		**$750.00**
Total Exam		**$1,100.00**

2. Review of the submitted documentation finds that the requestor billed $1100.00 for evaluations of Maximum Medical Improvement and Impairment Rating of four (4) requested body areas. The insurance carrier reimbursed $950.00. The Division finds that the requestor is entitled to reimbursement of an additional $150.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 15, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.